Second Annual Interim Report

Health Care Stabilization Fund Feasibility Board

December

2008

Contents

I. Background

The Health Care Stabilization Fund Feasibility Board (HCSFFB) was created pursuant to House Bill 1837, which was signed into law in 2006. The HCSFFB was charged with assessing the desirability of establishing a stabilization fund to provide excess professional medical liability insurance to Missouri health care providers, and to make recommendations to the legislature about how such a fund might best be structured. This is the second annual interim report of the HCSFFB.

Background HB 1837

In the early part of this decade, the medical malpractice market in both Missouri and nationally experienced a severe contraction. While competing explanations for the contraction have been offered from a variety of parties, there is at least general agreement that the market in many states had reached a crisis level. In Missouri, large malpractice carriers became insolvent; others stopped issuing new business or pulled out of the market altogether. In 2002, many Missouri physicians found themselves lacking liability insurance and scrambling to find coverage in a market that had contracted by over half.[1]

As policy makers at all levels of government attempted to craft a response, they were confronted by a lack of the detailed and credible data. The Government Accountability Office concluded that "…adequate data do not exist that would allow us and others to provide definitive answers to important questions about the market for medical malpractice insurance, including an explanation of the causes of rising losses over time and the precise effect of tort reforms on premium rates. This lack of data is due, in part, to the nature of regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency. However, comprehensive data on individual awards actually paid in malpractice cases are also lacking, as are data on conditions

[1] Missouri Department of Insurance. *Medical Malpractice Insurance in Missouri – The Current Difficulties in Perspective.* February, 2003.

in the health care sector that might affect the incidence and severity of medical malpractice suits."[2]

Similarly, the National Association of Insurance Commissioners concluded a study by also recognizing the deficiency of states' data collection efforts: "One of the underlying themes in nearly every piece of literature reviewed for this study, as well as the authors' own experiences with developing the report, was the fact that medical malpractice data was inconsistent, incomplete, difficult to obtain and even more difficult to interpret"[3]

House Bill 1837 mandated a significant expansion of the types of medical malpractice data to be collected in Missouri. Not only was such data intended to allow analysts to more fully assess the market and identify emerging trends quickly, the data are also designed to assist in helping malpractice carriers in developing rates. By allowing insurers to pool data across the state, a statistically credible database could be created that could provide additional stability in the malpractice market. The Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) is currently attempting to implement the data-related portions of the statute.

In addition, the legislature created the HCSFFB, which was charged with examining how a "stabilization fund" could help prevent a repeat of the earlier market contractions. The HCSFFB was established to assess the desirability of a state mandated or public excess medical malpractice provider. Such mechanisms, generally known as *health care stabilization funds (HCSFs)* or *patient compensation funds (PSCs),* are designed to provide coverage for malpractice payments that exceed an insured's primary coverage. Currently, nine states have implemented a HCSF in some form: IN, KS, LA, NE, NM, NY, PA, SC, and WI.

The structure of these state funds varies considerably across states. They may be administered through a state agency or as a quasi-independent public board. Participation in such funds may be mandatory for all physicians in a state, or they may be voluntary. Most HCSFs set premium rates that are sufficient to cover all claims and administrative costs, though NY provides some public subsidies to its fund.

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[2] Government Accountability Office. *Medical Malpractice Insurance. Multiple Factors Have Contributed to Premium Rate Increases.* Statement of Richard J. Hillman, Director, Financial Markets and Community Investment, and Kathryn G. Allen, Direct, Health-Care-Medicaid and Private Health Insurance Issues, to House of Representative, Subcommittee on Wellness and Human Rights, Committee on Government Reform. 10/1/2003.)

[3] National Association of Insurance Commissioners (NAIC). September 12, 2004. *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis.* Eric Nordman, Davin Cermak, and Kenneth McDaniel.

Some have argued that HCSFs can help to reduce overall rates by virtue of their status as non-profits, and by reducing some administrative expenses such as commissions or advertising. In addition, particularly for states with mandatory participation, rates may be lowered by spreading risk over a much larger population than would be possible for a single private insurer. By insulating the private market from the impact of very high-end claims, HCSFs can ameliorate the periods of rapid destabilization that have been a hallmark of medical malpractice insurance markets. As discussed in greater detail below, the HCSFFB has examined the operation of such finds, focusing particularly upon the operation of the Kansas fund.

II. Structure of the HCSFFB

The board consists of 10 members. Two members of the senate were appointed by the president pro tem, and two members of the house were appointed by the speaker of the house. In addition, the director of DIFP is a member, and also charged with appoint five additional member.

The 10 members of the board are:

1. Senator Bill Stouffer, Chairman
2. Senator Victor Callahan
3. Representative Rob Schaaf
4. Representative Curt Dougherty
5. John Stanley, MD, representing family physicians
6. Steve Reintjes, MD, representing medical doctors
7. Lancer Gates, DO, representing osteopathic doctors
8. Gloria Solis, RN MSN, MBA representing nurses
9. David Carpenter, representing Missouri hospitals
10. Linda Bohrer, Acting Director of DIFP/or her designee

Mission

The board is charged with completing a comprehensive study of the need for a health care stabilization fund, and assessing how such a fund might benefit Missouri's medical malpractice market. Among the questions currently under consideration by the board is whether a stabilization fund may be needed in the entire state, in a specific region of the state or for certain high risk medical specialties (such as neurological surgeons and/or obstetrician-gynecologists). In carrying out their charge, the board is directed to analyze medical malpractice claims, base rates, actual premiums charged, loss exposure, and other available data. The board may also study the experiences of other states such as Kansas which established a health care stabilization fund in 1976. Finally, if the board determines that a health care stabilization fund is necessary, it will make recommendations as to how the fund could be structured, designed and funded.

III. Board Activities in 2008

A. Determine the level of interest among medical practitioners in establishing a fund.

The board surveyed the memberships of the Missouri State Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons to determine members' level of interest in establishing a stabilization fund. While support for establishing a fund varies considerably by region, the overall survey results indicate a high level of support for such a fund among Missouri's physicians.

As a caveat, readers are cautioned that results are suggestive, and should not be taken as precise statistically valid or estimates representative of the attitudes of the general population of Missouri physicians. Mail surveys typically suffer from low response rates, and may entail biases associated with "self-selection" such that the attitudes of those motivated to respond may not be typical of the overall target population. The level of potential biases is unknown. However, other methods, such as telephone surveys, are prohibitively expensive in relation to the resources available to the HCSFFB.

Of providers who responded, 78 percent supported the creation of a health care stabilization fund in Missouri. Support was strongest in the Kansas City area, where fully 95 percent of respondents supported the fund. However, a majority of respondents from all regions also expressed support.

Question 1: Would you support the creation of a health care stabilization fund in Missouri?		
Response	**Number**	**Percent**
Yes	182	78.1%
No	51	21.9%
Total	**233**	**100%**

By Region	Number Supporting Fund	Number Opposed to Fund	% Supporting Fund
Columbia / Jefferson City Area	19	4	82.6%
Kansas City Area	52	3	94.5%
St. Louis Region	41	18	69.5%
Remainder of State	70	26	72.9%

Majorities also supported making participation in the fund mandatory for all practitioners. Among all respondents, including those who did not favor establishing a fund, 55 percent supported mandatory participation if such a fund were created. Among those who supported the creation of a fund, 67 percent felt that participation in the fund should be required.

Question 2: If a health care stabilization fund were established in Missouri, should participation be mandatory?		
All Respondents		
Response	**Number**	**Percent**
Yes, all physicians in Missouri should be required to participate	126	54.8%
Yes, but only for those physicians practicing in areas of Missouri experiencing affordability and availability problems	14	6.1%
No, participation should be purely voluntary	90	39.1%
Total	**218**	
Only those favoring establishing a stabilization fund		
Yes, all physicians in Missouri should be required to participate	121	67.2%
Yes, but only for those physicians practicing in areas of Missouri experiencing affordability and availability problems	9	5.0%
No, participation should be purely voluntary	50	27.48
Total	**180**	**100.0%**

Opinion was more evenly divided regarding the appropriate "attachment point" for excess coverage. A plurality of respondents favored the highest level of $1 million. That is, the private market would provide coverage up to $1 million per claim, and the fund would cover claim payments in excess of this amount.

Question 3: What do you believe should be the "attachment point," of the amount of a claim above which would be covered by the health care stabilization fund?		
Response	**Number**	**Percent**
$200,000	51	24.6%
$500,000	69	33.0%
$1,000,000	83	39.7%
Other amount	6	2.9%
Total	**209**	

Respondents were encouraged to express additional concerns about the possible fund. These responses are categorized in the following table. The most prevalent concern was that the existence of an excess fund would encourage additional lawsuits or higher awards. Some respondents suggested that the fund be modeled on the KS fund. Other concerns were that the fund might not adequately distribute the premium burden across various specialties; how such a fund might impact retired or non-practicing physicians; the impact on physicians working in more than one jurisdiction or state; the impact on federal employees; and concern that a fund might supplant coverage already provided by employers.

Concerns offered by respondents	**Number mentioning concern**
Fund would spawn more lawsuits / higher awards	13
Model on KS Fund	8
Focus should be on tort reform	7
Distribution of premium burden among specialties	4
Concern about assessing retirees / non-practicing physicians	3
Should not supplant employer provided coverage	3
Should be subsidized with public funds	2
Solvency issues/how shortfalls would be recouped	2
Accommodation of physicians working in multiple states	2
Doubt fund would lower premiums	1
Federal employees or others should be exempt	1
General distrust of government	1
No affordability / availability problem	1
Not enough information to make a decision	1
Possible political influence / funds used for other purposes	1

B. Consider Possible Data Collection

The Board continues to press for the collection of additional data, both via the formal adoption of rules to implement the provisions of House Bill 1837 as well as through other means.

1. One of the significant data deficiencies identified by the Board is the dearth of information about the availability of medical services around the state. While the state licensing board collects much useful information, neither the licensure nor renewal applications request information about whether a physician actively practices in Missouri, where they practice, what medical specialties are available, and what critical services are provided. The Board and DIFP coordinated efforts with the Missouri Department of Health and Senior Services, the Department of Rural Health and the Office of Social and Economic Data Analysis (OSEDA), both housed within the University of Missouri – Columbia.

Recommendations are presented in Appendix 1. Prior to these changes, the state of Missouri had no way to determine whether portions of the state were experiences shortages in critical medical specialties and services. In addition, the data will provide an additional verification for medical malpractice information collected by the DIFP.

The State Board of Healing Arts approved recommendations to modify the licensure and renewal applications on April 11th (see Appendix 2). Data should become available by early 2009.

2. The DIFP is currently in the process of adopting regulations to collect market surveillance and rate-making data pursuant to House Bill 1837. Initial attempts to promulgate a regulation failed due to strong objections by malpractice providers to submitting sensitive data in the absence of clear and unambiguous statutory protections to ensure the privacy of such data. In 2007, the Board recommended the adoption of legislation that would ensure that sensitive data, particularly personally identifying information, would be protected against disclosure. When the legislation failed to pass, the DIFP and interested parties developed compromise language for a new regulation. It is

believed that existing statutory privacy protections, such as the exemption of trade secrets from the state's sunshine law, already afford significant protections against disclosure. In addition, the DIFP developed clear rules governing the manner and form in which such data may be released. It is hoped that the new rules are again encountering challenges from medical malpractice insurers and self-insured hospitals. If the department is able to prevail in the rule-making process the rules will become effective in the first half of 2009 and begin receiving data early the following year.

The Board again recommends that legislation be introduced during the 2009 legislative session to extend confidentiality protections beyond those that can be accomplished via regulation.

C. Investigation of stabilization fund experience in other states

The Board narrowed the focus of analysis to the Kansas Health Care Stabilization Fund. Since the Kansas fund has experienced significant modification over several decades, the experience provides Missouri policymakers with greater insight into how such a fund might be structured, and problems that might be avoided.

In March of 2008, Chip Wheelen, executive director of the fund, made himself available for a detailed discussion of the fund's operations. Chip discussed necessary adjustments made to fund over the years, including removing caps on reserves, requiring doctors to participate in the fund for a minimum of five years before being eligible for tail coverage (to cover retirement or moves out of state), and surcharging doctors during the first five years. The fund also covers Kansas physicians practicing in Missouri, though coverage is subject to a 25 percent surcharge.

The board would like to express appreciation for the openness and availability of members of the Kansas stabilization fund. If a recommendation is made to establish a fund in Missouri, the efforts would benefit significantly by closely scrutinizing the experience of the Kansas fund.

D. Consideration of the Joint Underwriting Association

The Missouri Medical Malpractice Joint Underwriting Association (JUA) began issuing policies effective June, 2004. The JUA was established pursuant to 383.155 RSMo as a quasi-public provider of malpractice coverage in instances where such coverage is not reasonably available in the private market.

In March, the HCSFFB heard from Andrew Teigen, who spoke on behalf of the JUA. Andrew identified what he believed were deficiencies with the structure of the JUA:

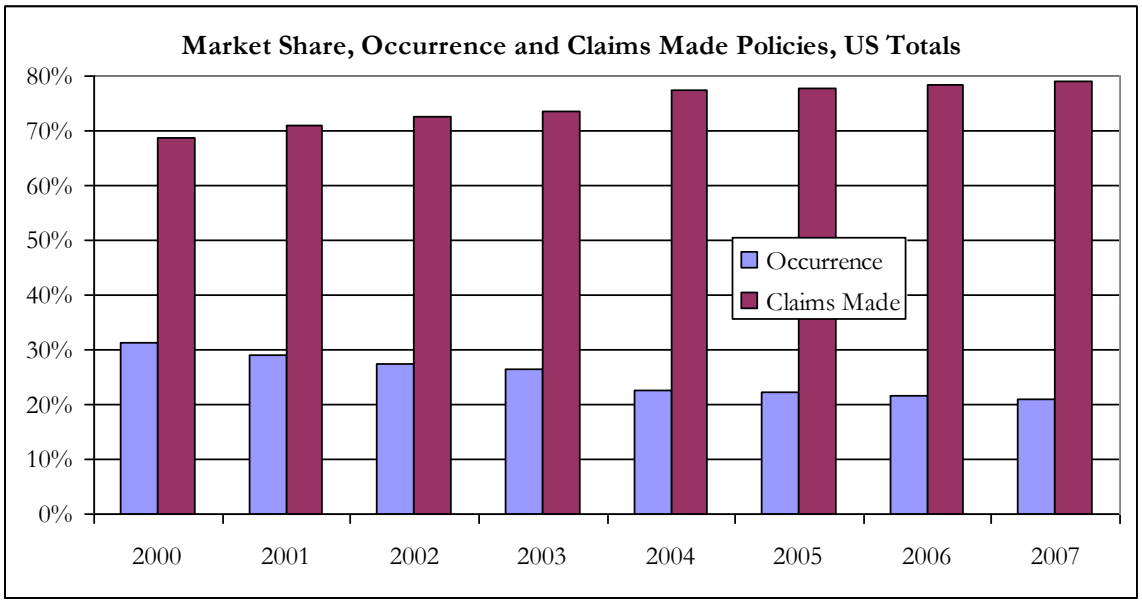
1. The JUA is required by statute to impose a one-time surcharge on insureds that is equal to the first year premium. This surcharge appears to have been designed to ensure that the JUA is able to accumulate sufficient reserves to cover future liabilities. After several years of operation, Andrew questioned whether the surcharge should be maintained at the present rate, or reduced to ensure that the JUA can provide affordable coverage.

2. Missouri statute limits JUA coverage to "occurrence" policies, or policies that cover adverse medical incidents occurring during the coverage period, regardless of when a claim is actually reported. The JUA is unable to write the much more prevalent "claims made" coverage, which provides coverage during the period in which a claim is reportedmade. Actuaries generally agree that liability risk under claims made policies are amenable to more accurate projections and therefore pricing. Andrew suggested that the restriction on the issuance of claims made policies limits the ability of the JUA to fully serve as an insurer of last resort in the medical malpractice market.

As the data in the following table indicate, between 2000 and 2007, the market share of occurrence coverage has declined by 10 percentage points, from 31.2 percent to 21.0 percent.

Market Share, Occurrence and Claims Made Policies US Total, 2000-2007				
	Premium Earned (000's Omitted)		Market Share	
Year	Occurrence Coverage	Claims Made Coverage	Occurrence Coverage	Claims Made Coverage
2000	$3,721,264	$8,202,616	31.2%	68.8%
2001	$3,798,161	$9,338,990	28.9%	71.1%
2002	$4,727,952	$12,592,997	27.3%	72.7%
2003	$5,537,888	$15,317,066	26.6%	73.5%
2004	$5,012,121	$17,058,864	22.7%	77.3%
2005	$5,271,478	$18,285,821	22.4%	77.6%
2006	$5,005,997	$18,075,237	21.7%	78.3%
2007	$4,677,388	$17,586,823	21.0%	79.0%

Source: Calculated by DIFP from insurers' financial annual statements, Schedule P, Part 1F.



Source: Calculated by DIFP from insurers' financial annual statements, Schedule P, Part 1F.

The board recommends that the structure and performance of medical malpractice JUAs in other states be examined to determine how the JUA may be optimally restructured. Items to consider are:

1. What level of surcharge is optimal?
2. Should the JUA offer claims made policies?
3. Should there be other "gate keeper" procedures in place to ensure that the JUA is truly an insurer of last resort? For example, should applicants provide proof of several declinations from traditional insurers before they are eligible for JUA coverage?

The HCSFFB believes that the JUA is a necessary component of the malpractice market, particularly during periods of restricted availability of coverage. Effort should be made to ensure that the JUA is able to function efficiently and as intended.

E. Monitoring the state of the medical malpractice market in Missouri

The Board continues to monitor the affordability and availability of medical malpractice insurance in Missouri. All indicators suggest that the market contraction observed during the early part of this decade has resolved favorably. Based on data provided by the DIFP, insurers experienced a return to profitability after significant losses in the early part of the decade. Claims costs have significantly declined, relieving upward pressure on premium rates.

1. In 2007, average indemnity declined for the third consecutive year. In 2004, the average payment per claim was $250,311, which had declined by 23 percent to $192,494 in 2007.

2. The number of pending claims has declined significantly during the same time period.[4] As of December 31st 2004, 4,403 malpractice claims were open. By year-end 2007, there were 25 percent fewer such claims, or 3,296.

[4] Comparisons exclude the anomalous year 2005, when the implementation of tort reform produced an historically unparallel increase in newly filed claims. Figures for 2005 and other years are presented in the appendix.

3. Also during 2007, insurers experienced positive returns on malpractice for the fourth consecutive year.

However, malpractice markets tend to experience cyclical contractions, such that deliberations about the desirability of a stabilization fund should not discount the possibility of future market disruptions. The board will continue to monitor the market as it proceeds with assigned tasks.

F. New uses for currently available data

The DIFP has collected medical malpractice claims data for nearly three decades. These data include narratives describing the leading to adverse medical outcomes. Beginning in 2006, the DIFP began a pilot project to determine if codification and statistical analysis of these narratives could reveal patterns that might alert medical practitioners to high concentrations of risk. During the September 12th meeting of the HCSFFB, the DIFP presented the results of this effort.

The HCSFFB encouraged the department to continue this work. A summary of the presentation is presented in Appendix 4.

Appendix 1: Questionnaire for Survey of Physicians

Dear Missouri Physician:

This survey is being sent to you on behalf of the Health Care Stabilization Fund Feasibility Board (HCSFFB). The HCSFFB was established by legislation to assess the desirability of a state mandated or public excess medical malpractice provider. Such mechanisms, generally known as *health care stabilization funds (HCSFs),* are created through legislation to provide coverage for malpractice payments that exceed an insured's primary coverage. Currently, nine states have implemented a HCSF in some form: KS, IN, LA, NE, NM, NY, PA, SC, and WI.

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Some have argued that HCSFs can help to reduce overall rates by virtue of their status as non-profits, and by reducing some administrative expenses such as commissions or advertising. In addition, particularly for states with mandatory participation, rates may be lowered by spreading risk over a much larger population than would be possible for a single private insurer. By insulating the private market from the impact of very high-end claims, HCSFs can ameliorate the periods of rapid destabilization that have been a hallmark of medical malpractice insurance markets. Past crises were marked by insolvencies, market exits, more restrictive underwriting criteria and rapidly rising rates among remaining insurers.

As a physician licensed to practice medicine in Missouri, we are very interested in your opinions on this matter.

1. Would you support the creation of a health care stabilization fund in Missouri?
   A. Yes
   B. No

2. If a health care stabilization fund were established in Missouri, should participation be mandatory?
   A. Yes, all physicians in Missouri should be required to participate.
   B. Yes, but only for those physicians practicing in areas of Missouri experiencing insurance affordability and availability problems.
   C. No, participation should be purely voluntary.

3. What do you believe would be the most appropriate "attachment point," or the amount of a claim above which would be covered by the health care stabilization fund?
   A. $200,000
   B. $500,000
   C. $1,000,000
   D. Other (please specify) _____

4. Please provide any additional comments or suggestions.

Appendix 2 Proposed revision to medical licensure application and renewal forms

Missouri State Board of Registration For The Healing Arts
P.O. Box 7001
Jefferson City, MO 65102
(573) 751-0098 or toll free (866) 289-5753

APPLICATION TO RENEW
PHYSICIAN AND SURGEON LICENSE
February 1, 2008 – January 31, 2009
FEE: $135.00 **
***** ONE YEAR RENEWAL FEE *****

FOR OVERNIGHT DELIVERIES: 3605 MISSOURI BLVD., JEFFERSON CITY, MO 65109

Online Renewal PIN Number: _____

To renew your license online go to https://renew.pr.mo.gov

MED License Number: (Pre-filled from current data, if available – all editable by user)

Primary Contact address is listed as: (Pre-filled from current data, if available – all editable by user)

Physician Name, MD
111 Doctor's Plaza
Suite 304
Cityname, MO 65432
Telephone (required)

Edit Primary Contact Information

Social Security Number: (Pre-filled from current data, if available – all editable by user)
Edit SSN

Email address: (Pre-filled from current data, if available – all editable by user)
Edit Email Address

The Missouri State Board of Healing Arts lists the following addresses as your home and/or business contacts. Please make any necessary changes.

Home Address:

Address 1
Address 2
City, State, Zip
Telephone (required)

(Pre-filled from current data, if available – all editable by user)

Edit Home Address

Primary Business Address:

Name of Business/Clinic/Office
Address 1
Address 2
City, State, Zip
Telephone (required)

Facility Type: (Pull-down list of facility types)

Direct Patient Care hours in an average week _____

Of the above Direct Patient Care hours, number of hours as Primary Care Physician/Provider _____

Number of days in average week on Call _____

(Pre-filled from current data, if available – all editable by user)

Edit Primary Business Address/ Practice Details

Secondary Business Address:

Name of Business/Clinic/Office
Address 1
Address 2
City, State, Zip
Telephone (required)

Facility Type: (Pull-down list of facility types)

Direct Patient Care hours in an average week _____

Of the above Direct Patient Care hours, number of hours as Primary Care Physician/Provider _____

Number of days in average week on Call _____

(Pre-filled from current data, if available – all editable by user)

Edit Secondary Business Address/ Practice Details

Add Another Business Address

(User can add as many business addresses as necessary to describe the practice)

If your phone number is not listed, please list it here. _____ This information is *required.* (Note: This can be handled in the address section by requiring the addition of a telephone number, so we could streamline that part of the form.)

What is your preferred method of contact?
___ Mail to Business ___ Mail to Home ___ Email ___ Phone

Demographic information:

Date of Birth: mm/dd/yyyy (populated from database, if available)

Gender: ○Male ○Female

Race: Pull-down menu with census categories
Ethnicity: ○Hispanic ○Non-Hispanic

If you are able to provide services in a 2nd language, please indicate (language pull-down list)

Pursuant to Section 324.010 RSMo:

☐ **CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**
False statements are subject to criminal penalties and/or license discipline.
If you have any questions regarding taxes contact the Department of Revenue at 573/751-7200 or e-mail income@dor.mo.gov.

1. Your current license expires January 31, 2008. Return this renewal notice and $135 renewal fee payable to the "STATE BOARD OF HEALING ARTS". All fees are non-refundable. Do not send cash through the mail.

Even though your license expires January 31, 2008, we strongly recommend that you return this renewal application and fee within two weeks of receipt of this application.
A PENALTY FEE OF $50 WILL BE ASSESSED FOR ANY APPLICATIONS POSTMARKED AFTER JANUARY 31, 2008. YOU SHOULD HAVE PROOF THAT YOUR LICENSE IS RENEWED BEFORE PRACTICING IN MISSOURI ON FEBRUARY 1 AND THEREAFTER. LICENSEES PRACTICING IN MISSOURI WITHOUT A RENEWED LICENSE ARE SUBJECT TO DISCIPLINARY ACTION BY THE BOARD OF HEALING ARTS, AND MAY BE REQUIRED TO REIMBURSE THIRD PARTY PAYERS.

2. **FOR NAME CHANGES ONLY**: A copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included with your renewal notice and payment.

3. ***Please note that if your license lapses and it is not renewed within two renewal periods of its expiration, your license will be considered void. To have it reinstated, you will need to apply for a new license as if you have never held a license in Missouri.***
If you wish to allow your license to lapse, retire your license, receive information on a limited license, or receive information on an inactive licensure status, please e-mail the Board of Healing Arts at healingarts@pr.mo.gov.

The Board of Healing Arts encourages you to visit its website for information regarding the Board's current activities, a copy of the most up-to-date rules and regulations, newsletters published by the Board, members of the Board and its staff, as well as other information pertaining to your profession. The website address is www.pr.mo.gov/healingarts.asp.

THIS INFORMATION IS REQUIRED FOR LICENSE RENEWAL
FOR ALL "YES" RESPONSES TO QUESTIONS 4 - 17, PLEASE EXPLAIN.
(for each question with a 'yes' answer, we can dynamically insert a text area for the required information to be entered online, except for the letter from question #4)

4. During the past 12 months, have you been diagnosed or treated for any mental or physical illness or condition that has hindered or might serve to hinder your ability to practice medicine? **If you answer yes to this question, please provide a letter from your treating physician stating**	○Yes ○No

your diagnosis and that your illness is not currently hindering your ability to practice medicine. Your license will not be renewed without a letter from your treating physician.	
5. During the past 12 months, have you, or any license or right to practice held by you, been restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any U.S. state, territory, federal agency, Canadian province or foreign country?	○Yes ○No
6. During the past 12 months, have you had any disciplinary or corrective action taken against you, or had your right to practice restricted, by any professional medical or osteopathic association or society, or by any licensed hospital or medical staff of a hospital?	○Yes ○No
7. During the past 12 months, have you surrendered a license issued to you by a U.S. state or any Canadian provincial licensing agency for any reason, other than failure to renew, retirement or relocating to another state?	○Yes ○No
8. During the past 12 months, have any charges or complaints been filed against you with the federal government, any federal agency or any U.S. state or Canadian provincial licensing or disciplinary agency?	○Yes ○No
9. During the past 12 months, have you been denied or surrendered a controlled substance license, registration, certificate or authority issued by the Drug Enforcement Administration (DEA) or any state bureau of narcotics or other agency concerned with controlled substances, or had such license, registration, certificate or authority restricted or disciplined, such disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not?	○Yes ○No
10. During the past 12 months, has any disciplinary action been taken against you, or has your authority to practice been restricted, by any federal or state agency including, but not limited to, Medicare or Medicaid?	○Yes ○No
11. During the past 12 months, have you forfeited collateral for breach or violation of any law, police regulation or ordinance whatsoever (other than minor traffic violations), been summoned into court as a defendant, or has any lawsuit (other than malpractice) been filed against you?	○Yes ○No
12. During the past 12 months, have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence, including a traffic violation related to alcohol or other chemicals?	○Yes ○No
13. During the past 12 months, have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself **for care provided in the State of Missouri**? **If you answer yes to this question, please complete the attached sheet in its entirety. One sheet needs to be completed for each action.** **(if yes, the following malpractice information form will dynamically appear for the physician to complete)** **MALPRACTICE INFORMATION FORM** **Attachment to 2008-2009 Application to Renew** ^ * A separate form should be completed for **each** malpractice action. This form should be completed for all malpractice actions that have been opened, are pending, have been dismissed, dropped, abandoned or settled within the last 24 months. ^ * Licensee's Name License Number (from database) Full name of PATIENT: _____ State where care was provided to patient: **MISSOURI**. If care was provided outside of Missouri, please check here. _____ No further information is needed. Patient's date of birth: _____ Patient's SSN: _____ Hospital(s)/Clinic(s) where care was provided to patient: _____ Court where malpractice action was filed: _____ Docket Number: _____ Status of the malpractice action: pending dismissed dropped settled Date malpractice action was settled or dismissed: _____ Money paid on your behalf: $_____ Name of Insurer/malpractice carrier _____ Did the patient die? Yes or No Date alleged injury occurred: _____ Explain the allegation:	○Yes ○No

_____ _____ _____ _____ _____ _____ Add a Malpractice Information Form	
14. The Board of Healing Arts' records indicate that you are American Specialty Board Certified or have obtained certification by the American Osteopathic Association in the following specialty(ies). If this information is incorrect, please note on the following line. (specialties loaded from database using prior information from licensing – users can edit, delete or add information as necessary) Specialty /Certification #1 **Edit Specialty** **Delete Specialty** Specialty /Certification #2 **Edit Specialty** **Delete Specialty** Drop-down list of specialties by code number Add Specialty	○Yes ○No
15. If you are currently the **primary supervising physician** in a collaborative practice arrangement with a nurse or the primary supervising physician in a supervision agreement with a physician assistant, please indicate the name of the person(s) with whom you are in the arrangement/agreement, their profession, license number, and the address and city of the office where you collaborate. Name of nurse/physician assistant and title (i.e. RN, APN, PA) License Number Street Address and City (previous responses could be loaded from the database) **Add an Assistant**	○Yes ○No

Services Provided:

Are you involved in direct Patient care? (if yes, skip the next 4 questions)	○Yes ○No
Retired from Active Practice	○Yes ○No
Temporarily Not in Practice	○Yes ○No
Employed in Non-Medical Field	○Yes ○No
Primarily Doing Research, Teaching or Administration	○Yes ○No
Are you providing obstetric deliveries?	○Yes ○No
Are you providing prenatal care?	○Yes ○No
Is your principal employer the federal government?	○Yes ○No
Are you currently in training? If you are currently in training, are you a (menu drop-down menu intern/resident/fellow)	○Yes ○No
Are you currently providing surgery?	○Yes ○No

Please indicate the type of medical malpractice (medical professional liability) insurance that best describes your current situation when you practice in Missouri:

I am practicing medicine and I am uninsured for medical malpractice claims.	○Yes ○No
I am not currently practicing medicine and I have no coverage for my prior medical practice.	○Yes ○No
I am not currently practicing medicine, but I have coverage for my prior medical practice.	○Yes ○No
I purchase an individual policy from an insurance company and my deductible is less than or equal to 10,000.	○Yes ○No
I purchase an individual policy from an insurance company and my deductible is more than $10,000.	○Yes ○No
I am a resident of Kansas and participate in the Kansas Health Care Stabilization Fund for	○Yes ○No

my practice in Missouri.	
I am insured as an owner or partner under a policy purchased for the group.	○Yes ○No
My employer provides insurance coverage or covers me through the program of self-insurance.	○Yes ○No
Other: Please describe _____	○Yes ○No

Listed below are the hospital affiliations (other than training hospitals) that we have on file for you. Please make any necessary changes.

Hospital #1 Date of Privileges **Edit Hospital** **Delete Hospital**
Hospital #2 Date of Privileges **Edit Hospital** **Delete Hospital**

List all of the states, territories or international countries in which you hold or have ever held a permanent, temporary or institutional license to practice medicine, in order of attainment. (Pre-populate from current license information and allow edits)

a. State 1	b. State 2	c. Country 1	d. State 3	

Edit license information

I certify that I am the person named in this application for renewal of license to practice medicine in the State of Missouri; **I have personally read, reviewed and answered each of these questions and certify that all statements I have made herein are true**; that I am the ori1ginal and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal.
Licensee's **ORIGINAL** Signature Date

Market Trends in Medical Malpractice
Missouri
2007

Presentation to the Health Care Stabilization Fund Feasibility Board

June 13, 2008

DIFP
Department of Insurance
Financial Institutions &
Professional Registration

Brent Kabler, Ph.D.
Research Manager
Statistics Section
Division of Market Regulation

Summary:

Profitability

Medical malpractice insurers earned a profit for the fourth consecutive year. Missouri insurers earned a rate of return in 2007 surpassed only in 1988 (31.7% vs. 35.1% of net worth). In addition, incurred losses were less than 14 percent of earned premium: the lowest in the DIFP's records dating back to the early 1980s. Missouri ranked fifth among states in terms of profitability. Only in five states did insurers fail to earn a positive rate of return.

Expressed as raw numbers, incurred losses declined by more than half between 2006 and 2007, and were only 1/6 of losses incurred in 2002.

Medical Malpractice
Missouri Premium and Incurred Losses

Year	Premium	Losses	Ratio
1998	$102,913	$61,336	59.6%
1999	$106,236	$77,021	72.5%
2000	$108,481	$75,286	69.4%
2001	$119,300	$102,479	85.9%
2002	$183,288	$205,649	112.2%
2003	$210,719	$189,436	89.9%
2004	$243,395	$126,565	52.0%
2005	$232,681	$114,712	49.3%
2006	$240,333	$72,821	30.3%
2007	$221,617	$30,805	13.9%

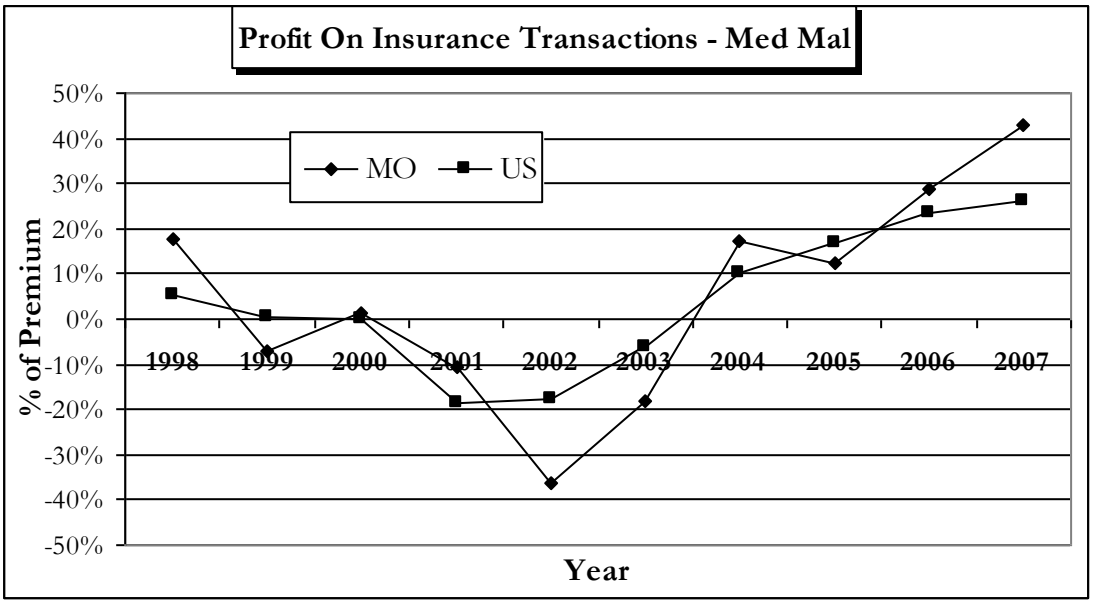
Source: Calculated from financial annual statements, 1998 - 2007

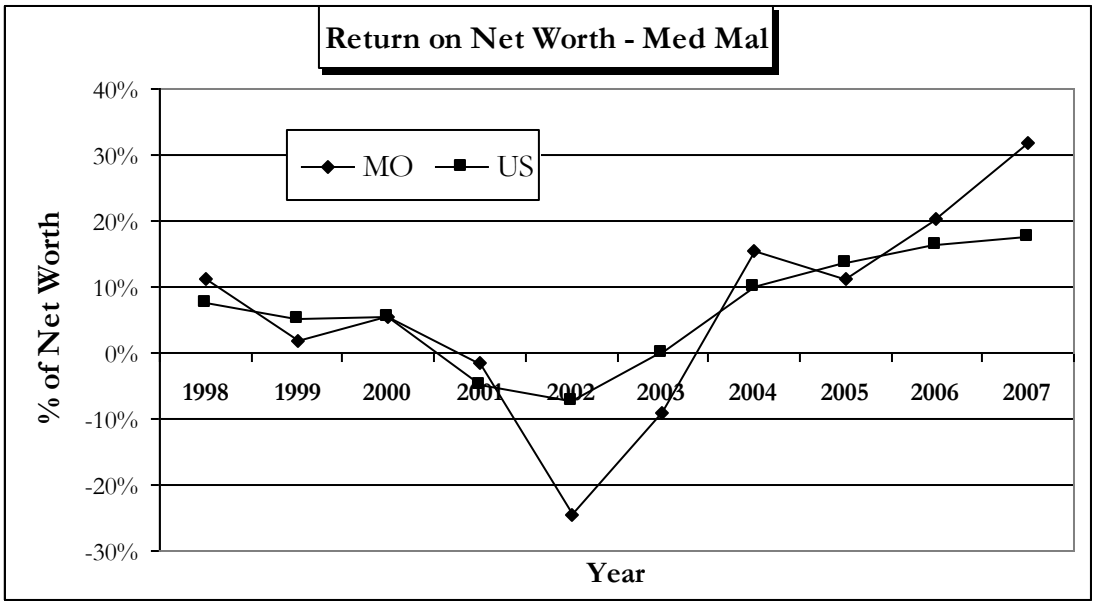
Missouri Profitability							
Year	Premium	Losses	LAE	Other Expenses	Investment + Taxes	Profit on Insurance Transactions	Return on Net Worth
1998	$102,913	59.6%	25.2%	21.6%	23.9%	17.5%	11.3%
1999	$106,236	72.5%	39.3%	23.1%	27.9%	-7.0%	1.8%
2000	$108,481	69.4%	36.6%	22.2%	29.6%	1.4%	5.5%
2001	$119,300	85.9%	30.6%	22.7%	28.4%	-10.8%	-1.4%
2002	$183,288	112.2%	35.5%	19.8%	31.1%	-36.4%	-24.4%
2003	$210,719	89.9%	38.6%	15.7%	26.0%	-18.2%	-9.0%
2004	$243,395	52.0%	24.5%	13.8%	7.5%	17.2%	15.4%
2005	$232,681	49.3%	34.9%	15.7%	12.2%	12.3%	11.2%
2006	$240,333	30.3%	26.6%	18.6%	4.4%	28.9%	20.3%
2007	$221,617	13.9%	17.7%	21.4%	-4.3%	42.7%	31.7%

Source: for 1998 – 2006, NAIC, ***Profitability by Line by State.*** *2007, calculated by DIFP based on NAIC profitability formula.*

Profitability - US							
Year	Premium	Losses	LAE	Other Expenses	Investment + Taxes	Profit on Insurance Transactions	Return on Net Worth
1998	$6,195,047	73.0%	32.4%	23.4%	34.2%	5.4%	7.6%
1999	$6,115,241	73.9%	32.4%	23.6%	30.5%	0.6%	5.1%
2000	$6,375,401	80.9%	32.5%	22.5%	35.8%	-0.1%	5.4%
2001	$7,060,512	100.0%	34.2%	21.8%	37.2%	-18.8%	-4.7%
2002	$8,936,921	93.0%	31.7%	18.9%	26.0%	-17.6%	-7.4%
2003	$10,646,118	80.7%	31.9%	16.1%	22.4%	-6.3%	-0.1%
2004	$11,583,419	62.9%	26.4%	14.4%	13.9%	10.2%	10.0%
2005	$11,941,705	51.9%	26.8%	15.6%	11.1%	16.8%	13.5%
2006	$12,192,432	43.0%	26.2%	16.3%	9.1%	23.6%	16.5%
2007	$11,717,146	41.4%	23.6%	19.1%	10.3%	26.2%	17.7%

Source: for 1998 – 2006, NAIC, ***Profitability by Line by State.*** *2007, calculated by DIFP based on NAIC profitability formula.*


Profit On Insurance Transactions - Med Mal
50%
40%
30%
20%
10%
0%
-10%
-20%
-30%
-40%
-50%
MO
US
% of Premium
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Year


Return on Net Worth - Med Mal
40%
30%
20%
10%
0%
-10%
-20%
-30%
MO
US
% of Net Worth
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Year

Profitability, Medical Malpractice, 2007 Sorted by Descending Return on Net Worth						
State	**Premiums Earned (000s)**	**Losses Inc**	**Loss Adj Exp**	**Profit on Ins Trans**	**Return on Net Worth**	**Rank**
New Hampshire	$42,748	-5.3%	5.8%	**62.9%**	**43.6%**	1
Texas	$412,146	-17.1%	9.4%	**70.4%**	**40.4%**	2
Nebraska	$35,942	22.0%	10.9%	**42.4%**	**33.9%**	3
Maine	$56,178	21.4%	10.8%	**42.3%**	**33.2%**	4
Missouri	**$221,617**	**13.9%**	**17.7%**	**42.7%**	**31.7%**	**5**
Ohio	$480,209	23.0%	9.6%	**43.1%**	**29.3%**	6
Iowa	$92,728	21.8%	24.0%	**33.4%**	**29.3%**	7
North Carolina	$305,400	35.6%	14.9%	**29.5%**	**26.1%**	8
Michigan	$249,233	17.3%	22.1%	**39.9%**	**26.0%**	9
Nevada	$110,543	14.2%	30.8%	**30.6%**	**25.5%**	10
Washington	$241,654	38.5%	18.1%	**27.3%**	**25.1%**	11
Minnesota	$99,677	40.1%	15.0%	**24.0%**	**24.5%**	12
Virginia	$286,592	28.3%	20.3%	**29.9%**	**24.3%**	13
North Dakota	$17,777	32.8%	18.0%	**30.0%**	**24.2%**	14
California	$913,780	26.2%	23.5%	**27.8%**	**24.1%**	15
Florida	$698,615	18.7%	17.3%	**39.9%**	**24.0%**	16
Montana	$47,154	34.6%	25.2%	**25.7%**	**23.6%**	17
Alabama	$160,867	30.3%	25.2%	**31.4%**	**21.7%**	18
Idaho	$44,338	31.9%	24.2%	**24.6%**	**21.4%**	19
Mississippi	$55,231	29.1%	12.7%	**38.3%**	**21.2%**	20
Colorado	$186,199	34.8%	21.8%	**24.8%**	**21.1%**	21
Delaware	$43,025	31.1%	20.2%	**26.2%**	**20.9%**	22
Georgia	$342,082	37.1%	21.8%	**28.7%**	**20.3%**	23
Oregon	$113,493	45.6%	19.8%	**23.7%**	**19.9%**	24
South Carolina	$53,733	35.7%	21.5%	**24.6%**	**19.7%**	25
Hawaii	$36,645	40.1%	13.9%	**23.6%**	**19.7%**	26
Tennessee	$348,123	33.0%	33.9%	**26.0%**	**19.3%**	27
Kansas	$96,958	35.5%	29.5%	**20.2%**	**19.1%**	28
Pennsylvania	$698,919	51.4%	17.6%	**22.8%**	**16.7%**	29
Louisiana	$106,249	7.1%	58.8%	**28.3%**	**16.5%**	30
Maryland	$326,443	31.1%	12.5%	**17.8%**	**16.5%**	31
Oklahoma	$132,397	44.6%	24.6%	**17.4%**	**15.6%**	32
Arizona	$285,525	43.0%	21.4%	**18.1%**	**14.7%**	33
Massachusetts	$307,069	52.4%	28.3%	**24.0%**	**14.2%**	34
South Dakota	$25,071	41.7%	30.2%	**12.8%**	**14.2%**	35
Illinois	$663,183	40.9%	30.1%	**22.2%**	**13.8%**	36
Indiana	$131,017	52.3%	24.1%	**18.8%**	**13.2%**	37
Utah	$70,677	41.3%	37.3%	**15.4%**	**13.1%**	38

Profitability, Medical Malpractice, 2007 Sorted by Descending Return on Net Worth						
State	**Premiums Earned (000s)**	**Losses Inc**	**Loss Adj Exp**	**Profit on Ins Trans**	**Return on Net Worth**	**Rank**
Rhode Island	$47,388	42.0%	35.8%	**19.2%**	**12.8%**	39
New Jersey	$590,433	59.9%	18.4%	**15.7%**	**12.5%**	40
Kentucky	$170,383	48.8%	32.0%	**12.9%**	**11.2%**	41
West Virginia	$87,570	51.9%	41.3%	**7.2%**	**6.7%**	42
New York	$1,645,306	75.7%	29.7%	**7.2%**	**6.6%**	43
Wisconsin	$115,072	57.1%	35.0%	**-1.0%**	**2.8%**	44
Connecticut	$219,402	93.8%	18.0%	**-2.6%**	**2.4%**	45
Alaska	$23,792	71.9%	23.3%	**-4.2%**	**0.4%**	46
New Mexico	$47,895	80.1%	32.4%	**-7.5%**	**-1.1%**	47
Arkansas	$83,671	75.8%	40.7%	**-9.7%**	**-2.1%**	48
DC	$40,656	97.9%	26.1%	**-12.1%**	**-2.4%**	49
Wyoming	$24,077	80.3%	27.6%	**-12.4%**	**-7.6%**	50
Vermont	$20,200	139.9%	36.5%	**-49.7%**	**-27.1%**	51
US Total	**$11,717,146**	**41.4%**	**23.6%**	**26.1%**	**17.7%**	

Source: Calculated by DIFP based on NAIC profitability formula.

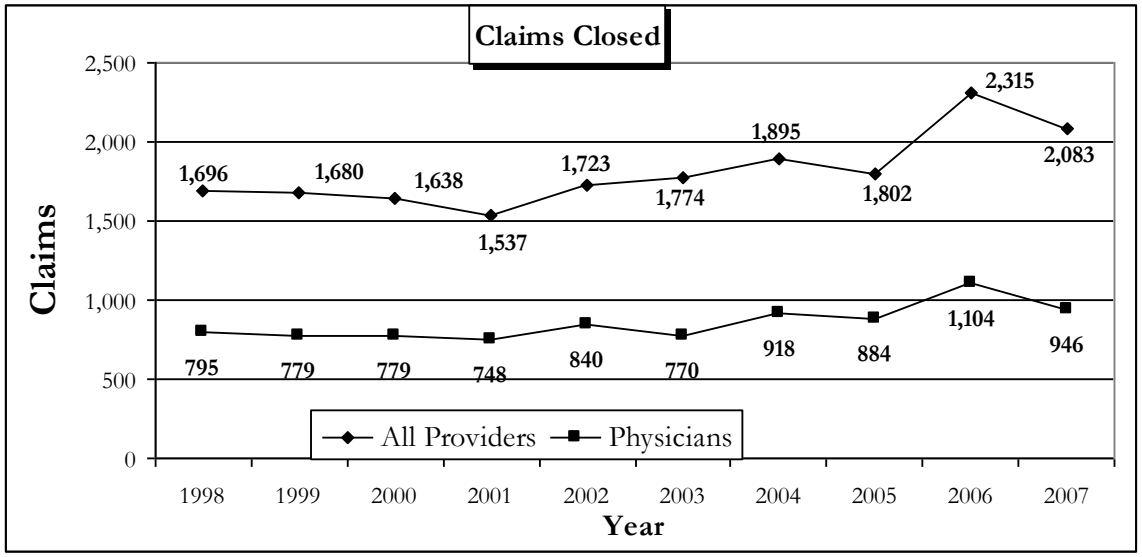
Claims

The number of claims closed declined substantially in 2007 compared to the prior year. However, the number of **paid** claims increased substantially. Paid claims for all providers increased from 502 to 623 between 2006 and 2007; and those for physicians and surgeons increased from 159 to 204. However, the number of newly reported claims declined significantly between 2006 and 2007. In addition, the number of claims outstanding at year end reached a 10 year low.

The increase in paid claims was partially offset by a decline in average indemnity paid, though on net insurer liability from claims closed in 2007 increased by 12 percent compared to the prior year, though the amount was still well below that of 2005.

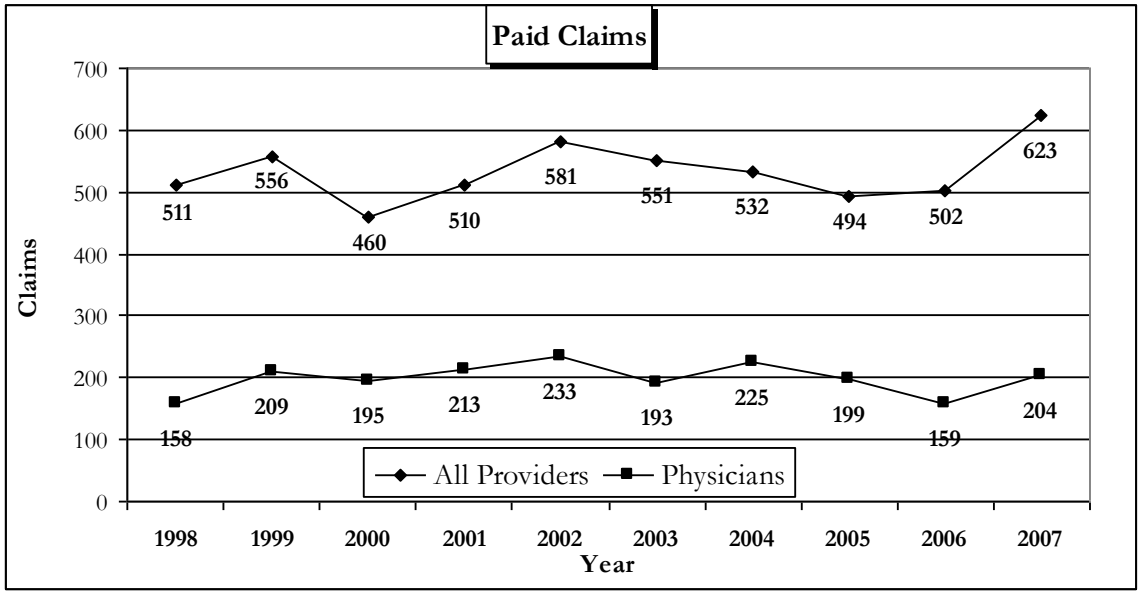
Closed Claims										
Practitioner Class	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Clinics / Corps	268	295	338	298	393	452	404	328	497	434
Physicians & Surgeons	795	779	779	748	840	770	918	884	1,104	946
Hospitals	373	385	300	316	291	344	352	377	423	475
Nurses	22	28	30	28	44	37	57	65	118	65
Nursing Homes	66	52	54	41	63	51	43	23	24	21
Dentists	133	115	104	77	72	74	67	78	78	72
Pharmacies	17	10	12	7	8	15	23	18	22	25
Optometrist	5	2	1	3	1		2	4	4	4
Chiropractors	11	7	18	17	7	16	19	12	20	16
Podiatrist	6	7	2	2	4	15	10	13	25	25
Total	**1,696**	**1,680**	**1,638**	**1,537**	**1,723**	**1,774**	**1,895**	**1,802**	**2,315**	**2,083**

Source: calculated from DIFP medical malpractice claims data.



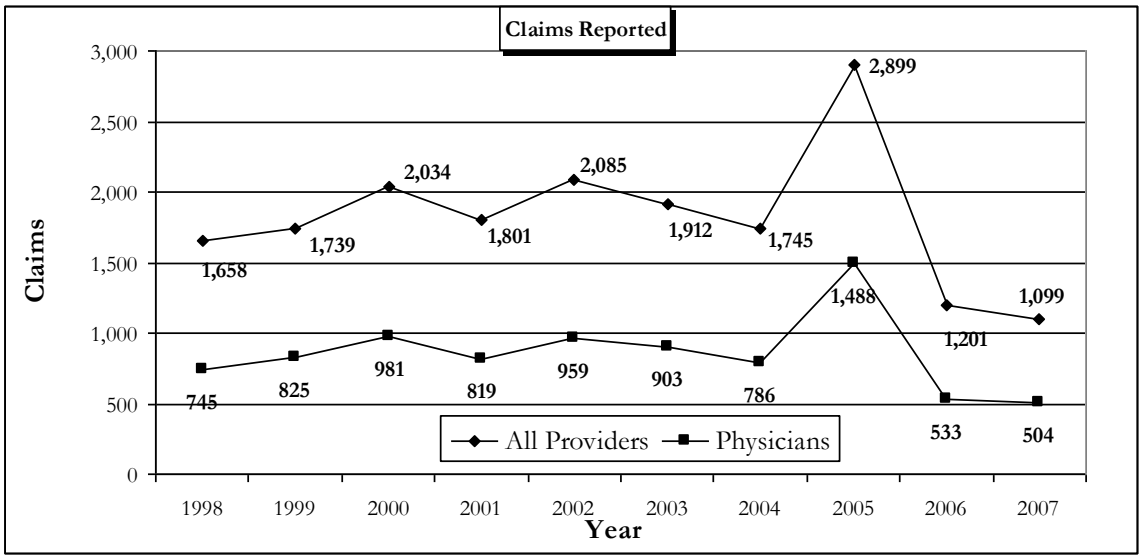
Paid Claims										
Practitioner Class	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Clinics / Corps	98	82	78	92	135	134	87	79	102	132
Physicians & Surgeons	158	209	195	213	233	193	225	199	159	204
Hospitals	127	165	104	127	115	140	132	147	162	201
Nurses	4	4	6	12	11	7	20	15	14	17
Nursing Homes	41	38	33	27	53	43	30	13	16	13
Dentists	59	46	24	22	21	16	14	15	20	19
Pharmacies	14	8	9	3	7	10	13	12	13	20
Optometrist	3	1		1	1		1		1	
Chiropractors	5	1	11	12	4	4	4	6	8	10
Podiatrist	2	2		1	1	4	6	8	7	7
Total	**511**	**556**	**460**	**510**	**581**	**551**	**532**	**494**	**502**	**623**

Source: calculated from DIFP medical malpractice claims data.



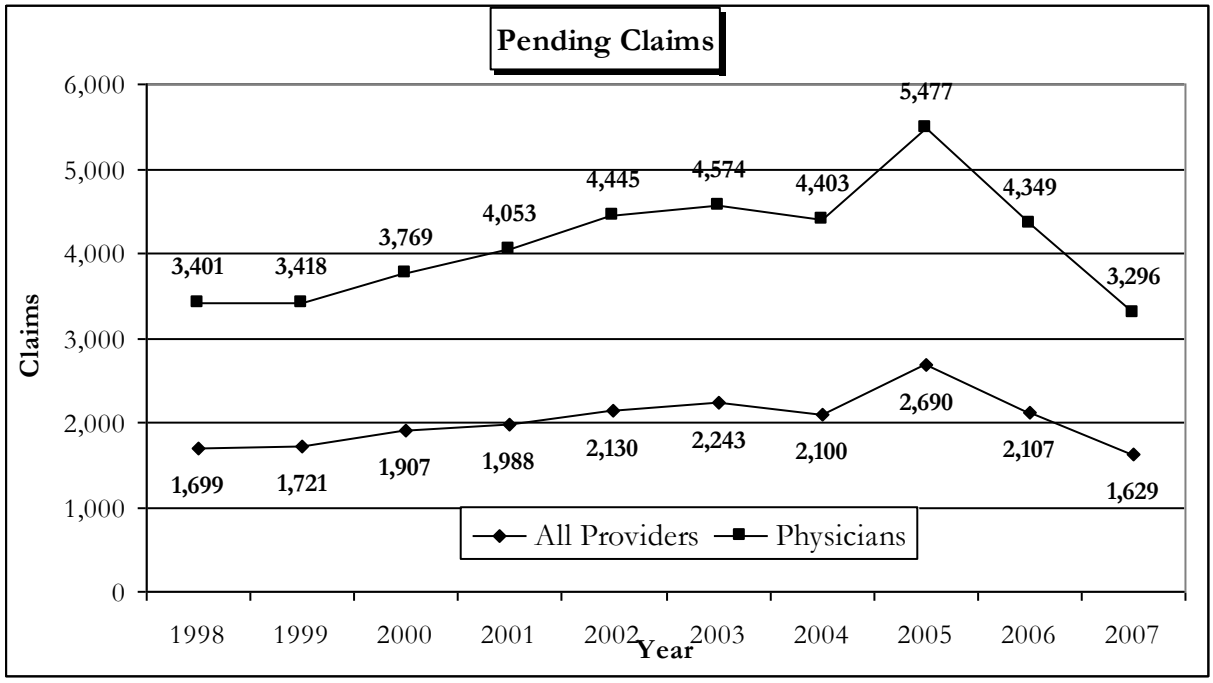
Claims Reported										
Practitioner Class	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Clinics / Corps	300	371	457	432	520	450	364	596	212	179
Physicians & Surgeons	745	825	981	819	959	903	786	1,488	533	504
Hospitals	377	310	352	340	377	355	368	510	276	276
Nurses	24	37	42	62	56	53	53	135	61	26
Nursing Homes	61	60	64	52	48	20	12	27	16	22
Dentists	116	97	107	69	80	72	100	77	59	58
Pharmacies	8	13	11	8	17	21	24	21	18	19
Optometrist	3	7	1		3	2	6	3	2	1
Chiropractors	16	12	15	14	14	21	15	17	13	3
Podiatrist	8	7	4	5	11	15	17	25	11	11
Total	**1,658**	**1,739**	**2,034**	**1,801**	**2,085**	**1,912**	**1,745**	**2,899**	**1,201**	**1,099**

Source: calculated from DIFP medical malpractice claims data.



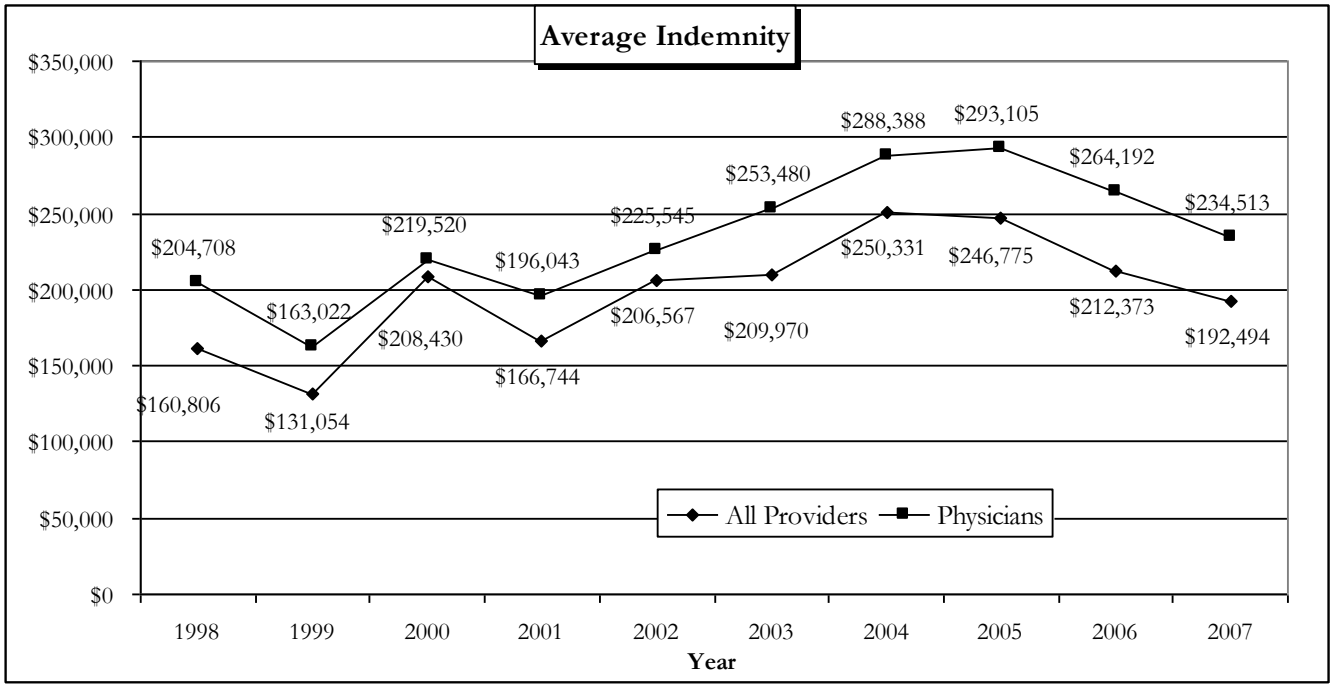
Pending Claims: Claims Open At Year End										
Practitioner Category	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Clinics / Corps	543	615	727	865	996	997	954	1,217	925	660
Physicians & Surgeons	1,699	1,721	1,907	1,988	2,130	2,243	2,100	2,690	2,107	1,629
Hospitals	837	755	796	822	909	929	939	1,067	920	714
Nurses	45	56	67	101	115	129	124	193	136	96
Nursing Homes	90	95	104	115	100	69	38	42	36	35
Dentists	148	124	120	113	123	120	154	155	140	115
Pharmacies	7	10	8	9	18	24	25	30	25	18
Optometrist	1	5	5	2	4	6	10	9	7	4
Chiropractors	22	28	25	23	28	36	31	35	27	14
Podiatrist	9	9	10	15	22	21	28	39	26	11
Total	**3,401**	**3,418**	**3,769**	**4,053**	**4,445**	**4,574**	**4,403**	**5,477**	**4,349**	**3,296**

Source: calculated from DIFP medical malpractice claims data.



Average Indemnity Per Paid Claim										
Provider Category	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Clinics / Corps	$212,141	$184,993	$290,437	$155,490	$276,001	$214,610	$401,963	$315,646	$294,423	$197,885
Physicians & Surgeons	$204,708	$163,022	$219,520	$196,043	$225,545	$253,480	$288,388	$293,105	$264,192	$234,513
Hospitals	$183,204	$106,778	$234,967	$156,494	$143,718	$189,746	$181,379	$205,719	$148,539	$181,408
Nurses	$32,119	$408,500	$56,253	$124,580	$118,886	$149,286	$94,411	$151,128	$301,252	$123,718
Nursing Homes	$73,032	$93,021	$127,201	$211,796	$191,456	$176,193	$180,628	$191,663	$203,344	$137,697
Dentists	$22,210	$15,074	$40,758	$12,907	$53,519	$88,645	$26,781	$110,601	$47,618	$91,812
Pharmacies	$77,454	$5,209	$22,364	$13,260	$5,193	$12,858	$20,755	$91,491	$37,653	$42,839
Optometrist	$9,756	$22,500	N/A	$800,000	$67,500	N/A	$870,000	N/A	$79,000	N/A
Chiropractors	$30,849	$15,000	$24,164	$59,613	$16,625	$37,925	$24,531	$32,189	$40,958	$171,975
Podiatrist	$35,000	$32,500	N/A	$50,000	$926,500	$282,375	$76,000	$86,713	$170,143	$183,571
Total	$160,806	$131,054	$208,430	$166,744	$206,567	$209,970	$250,331	$246,775	$212,373	$192,494

Source: calculated from DIFP medical malpractice claims data.



Tort Reform

While it is still too early to rigorously assess the impact of the 2005 tort reforms on claim patterns, some evidence is suggestive. As a caveat, please note that the following tables are a subset of claims, and includes only claims closed within a year after they were opened. These claims tend to be settled for smaller amounts than claims that claims of longer duration. Also note the relatively small N. As claims filed after the tort changes "age" and as more data comes in, a more complete picture will emerge.

Distribution of Claims Filed 14 month prior to and after tort changes
And closed within 1 year
All Providers

All Claims

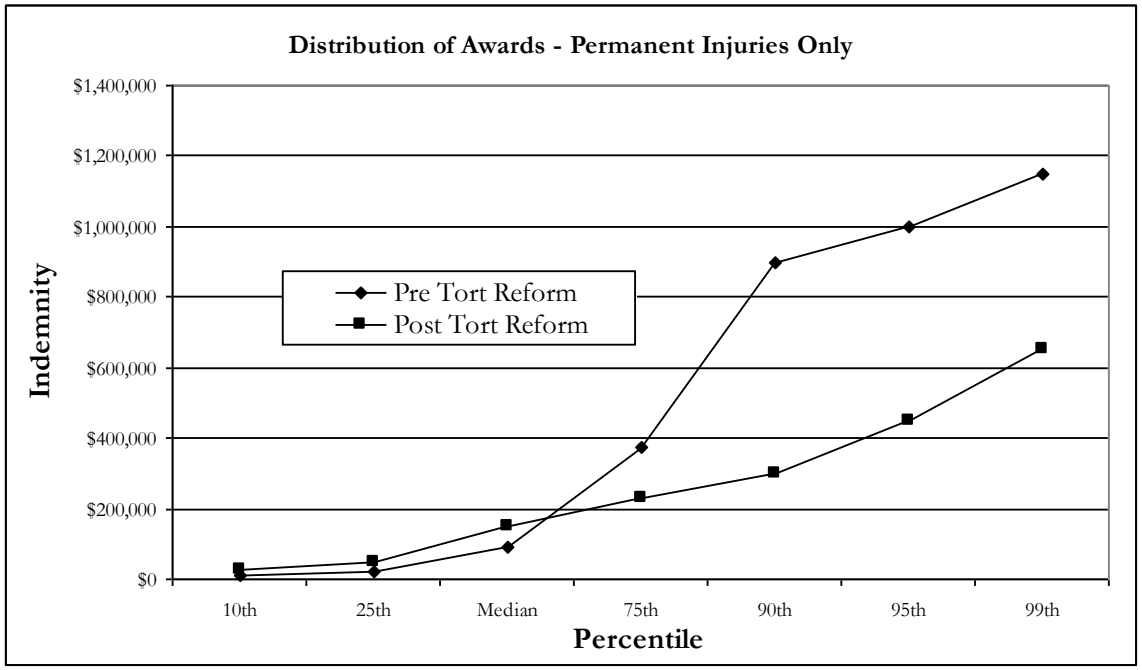
Percentile

	N	10th	25th	Median	75th	90th	95th	99th	Average
Pre Tort	105	$2,000	$4,662	$15,000	$65,000	$375,000	$475,000	$1,000,000	$107,155
Post Tort	138	$1,463	$5,000	$17,989	$70,000	$200,000	$262,500	$450,000	$61,122

Permanent Injuries Only

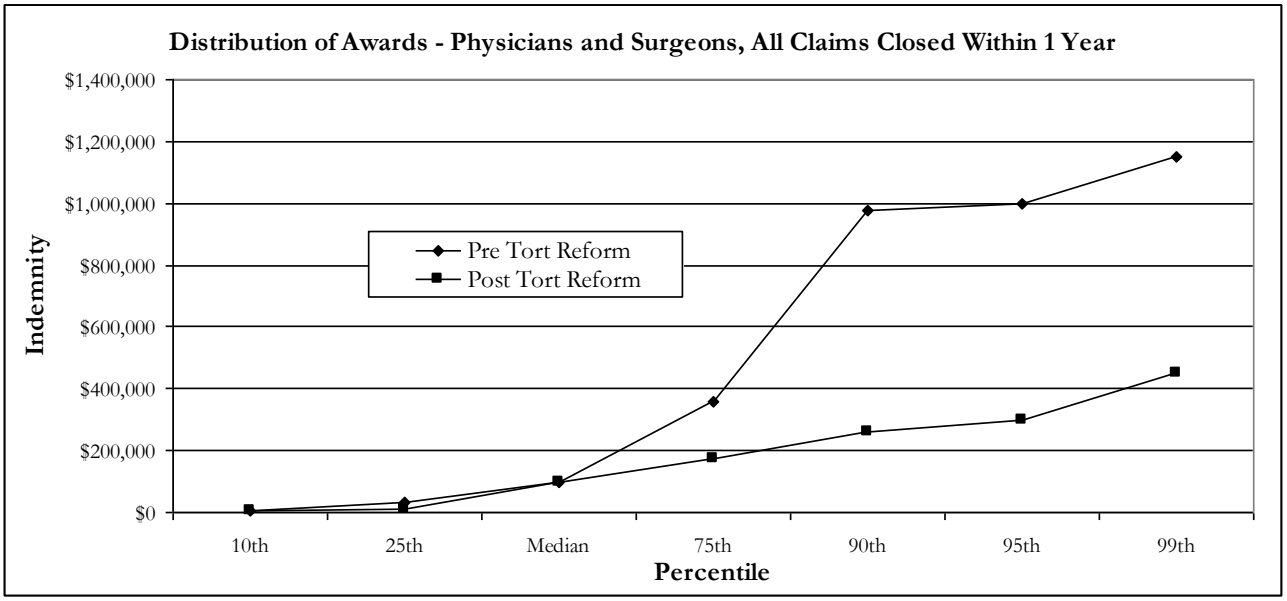
	N	10th	25th	Median	75th	90th	95th	99th	Average
Pre Tort	33	$10,000	$22,500	$90,000	$375,000	$900,000	$1,000,000	$1,150,000	$254,917
Post Tort	31	$24,814	$50,000	$150,000	$230,834	$301,035	$450,000	$650,000	$157,084

Source: calculated from DIFP medical malpractice claims data.



Distribution of Claims Filed 14 month prior to and after tort changes And closed within 1 year Physicians & Surgeons									
All Claims									
Percentile									
	N	10th	25th	Median	75th	90th	95th	99th	Average
Pre Tort	25	$7,000	$30,000	$100,000	$359,472	$976,118	$1,000,000	$1,150,000	$100,000
Post Tort	22	$3,804	$12,000	$95,000	$175,000	$262,500	$301,035	$450,000	$95,000

Source: calculated from DIFP medical malpractice claims data.



Brief discussion of possible indirect impact of tort reforms

Based on the limited data, it appears that indemnity amounts for claims filed after tort reforms became effective were closed for lower amounts at the upper region of the distribution. Interestingly, this is true of claims closed at amounts **well below** the cap on non-economic damages. For example, for all providers, claims at the 90th percentile that were filed after tort reform were associated with indemnity payments of $200,000, compared to similar claims filed pre-tort reform. However, the cap on non-economic damages was lowered from $575,000 to $350,000, so that this limit cannot have ***directly*** impacted these amounts.

However, there are plausible theories that suggest an indirect effect, primarily derived from game theory. Such theories attempt to specify a rational calculus of strategic "players" engaged in bargaining. A very simplified example of expected payoffs for a hypothetical plaintiff is illustrated in the following table.

Hypothetical Calculus of Utility - Plaintiff					
	Non-economic cap	**Economic Damages**	**Total Likely Award**	**Probability of Winning at Trial**	**Expected Value**
Pre-tort reform	$579,000	$300,000	$879,000	30.0%	$263,700
Post-Tort Reform	$350,000	$300,000	$650,000	30.0%	$195,000
% Difference	**-39.6%**	**0.0%**	**-26.1%**	**0.0%**	**-26.1%**

Game theory suggests that individuals behave strategically, and possess a sense of likely payoffs or outcomes from range of possible decisions. A plaintiff's expected utility of pursuing a case to trial is tied to their assessment of the amount that will likely be awarded, discounted by the probability of a verdict for plaintiff. In the above example, a plaintiff representing a client with $300,000 in economic damages and possible non-economic damages of $579,000 may expect an award of $879,000, if successful at trail. This amount is discounted by their assessed probability of success. In the above example, this is ($879,000 * 30%) = $263,700. Excluding the impact of litigation costs and other external factors (such as a desire to be validated at trial), the plaintiff ought to be willing to settle the case for this value (or more accurately, a range a values based on their assessed probability distributions of various trial outcomes).

Tort reform reduced the cap on non-economic damages to $350,000. Performing the same calculations as above, a plaintiff now ought to be willing to settle for $195,000, or 26% less than their pre-tort reform position. Note that these amounts are well below any *direct* possible impact of the cap. It is thus possible that a cap can have indirect effects on bargaining behavior that impact claims settled for amounts well below the cap's value.

In addition, some scholars have suggested that caps can increase the likelihood of negotiated settlements in some circumstances, possibly further reducing adjustment and litigation costs.

Again, this discussion should be taken as somewhat speculative or suggestive, given the paucity of current data. The interested reader is referred to

Pogarsky, Greg, and Linda Babcock. *Damage caps, motivated anchoring, and bargaining impasse.* (August 1, 2000). Available at SSRN: http://ssrn.com/abstract=235296

Appendix 4: New uses for existing data

Causes and Consequences of Adverse Outcomes: New Uses for Medical Malpractice Data

Missouri Department of Insurance

Presentation to the Health Care Stabilization Fund Feasibility Board

Kansas City

9/12/2008

Brent Kabler
Missouri Department of Insurance

Non-insurance related uses of the data

Information about the nature of medical malpractice allegations can be used to identify high concentrations of risks to patients. Missouri has begun a program of developing taxonomies to codify and analyze various causes of errors. Claims filed with the DIFP include narratives describing the nature of the malpractice allegation. A pilot project was launched to determine if the narratives could be codified in a way that would identify meaningful trends. Notably, this effort makes use of information already collected by the department but has not been analyzed in the past.

The codes were designed to capture:

1. The initial illness or condition
2. Procedures that were performed
3. Actions that were taken, **and as importantly,** that were **not** taken but (allegedly) should have been.
4. The nature of the injury produced by the alleged error or omission.

Some events are of course quite simple in terms of identifying causal chains:

"Patient saw dr for pain in chest, x-ray was taken and read as negative, but turned out to be positive. Patient alleges failure to timely diagnose cancer and lost chance of survival."

Other outcomes entail significantly more complex events, where the causal sequence may contain many "necessary but not sufficient" events that lead to an injury. The taxonomies remain very much a work in progress.

Example findings:

Four categories of error account for about 30% of all paid claims.

- Infections
- Physical injuries sustain on premises (falls, attacks by third parties, etc).
- Surgeries or other procedures performed on the wrong body part of the wrong person
- Adverse events associated with medications and other therapeutic agents.

Allegation of Error or Omission	Occurrences	Paid Occurrences	Total Indemnity	Average Indemnity
Infections				
Infection subsequent to surgery	95	21	$6,188,008	$294,667
Contraction of staph infection	7	2	$515,000	$257,500
Contraction of meningitis	1		$0	
Contraction of hepatitis	3	1	$50,000	$50,000
Contraction of septic condition	5	3	$974,500	$324,833
Development of pressure ulcers during care	49	23	$3,675,576	$159,808
Contraction of gangrene or other necrotizing condition	1	1	$500,000	$500,000
Contraction of other disease or infection	45	11	$793,450	$72,132
Contraction of gangrene or other necrotizing condition	1	1	$500,000	$500,000
Subtotal	**207**	**40**	**$13,196,534**	**$329,913**
Physical Injuries Sustained While Under Care				
Falls on medical premises or while under care	145	70	$9,634,664	$137,638
Injury during lifting, transporting, or repositioning	24	16	$1,080,083	$67,505
Injury while being restrained	2	1	$211,400	$211,400
Failure to protect from 3rd party	7	2	$30,000	$15,000
Subtotal	**178**	**89**	**$10,956,147**	**$123,103**
Wrong Site / Wrong Person				
Surgery on Wrong patient	22	16	$1,943,900	$121,494
Surgery on Wrong body part	3	2	$100,000	$50,000
Other Procedure performed on wrong body part	2	1	$150,000	$150,000
Subtotal	**27**	**19**	**$2,193,900**	**$115,626**
Adverse Outcomes Associated with Medications and Therapeutic Agents				
Medication error - wrong dosage or wrong medication (Surgery Related)	8	6	$1,057,000	$176,167
Adverse reaction to correct medication (Surgery Related)	11	1	$150,000	$150,000
Allergic or other reaction to anesthetic	9	3	$264,500	$88,167
Wrong dosage or incorrect anesthetic	2	1	$225,000	$225,000
Wrong dosage	30	18	$6,710,589	$372,811
Wrong medication	53	32	$1,192,404	$37,263

Allegation of Error or Omission	Occurrences	Paid Occurrences	Total Indemnity	Average Indemnity
Wrong dosage or wrong medication (unclear from records)	11	1	$230,000	$230,000
Allergic reaction to medication	8	3	$337,000	$112,333
Interaction of two or more medications	8	4	$1,425,000	$356,250
Addiction or withdrawal issues	12	1	$50,000	$50,000
Toxicity associated with long term or excessive use	12	5	$561,000	$112,200
Other negative side effect of medications	150	26	$7,870,539	$302,713
Overdose of radiation during course of therapy	5	2	$565,828	$282,914
Birth Injuries due to medication errors	2	2	$2,050,000	$1,025,000
Mismatched blood used in transfusion	2	1	$950,000	$950,000
IV infiltration incident	14	6	$1,374,000	$229,000
Subtotal	**337**	**112**	**$25,012,860**	**$223,339**
Total (just four categories of error)				
Infections	207	40	$13,196,534	$329,913
Physical Injuries	178	89	$10,956,147	$123,103
Wrong Site / Wrong Person	27	19	$2,193,900	$115,626
Medications / Therapeutic Agents	337	112	$25,012,860	$223,339
Total	**749**	**260**	**$51,359,441**	**$191,122**

NB: This represents nearly 30 percent of the 908 paid occurrences that had enough information in the filed form to identify the error.

Another use of these types of data is to track the "efficiency" of malpractice markets with respect to how well they compensate injured parties. For example, it is often argued that payments are arbitrary and capricious and don't track that nature of the injury well. If this were true, then malpractice markets would rightly be considered "inefficient."

We have not found this to be the case. In fact, payments do tend to track injury severity. For this reason, the DIFP receives requests from insurers who sometimes will try to value a case based on past settlements.

Allegation of Error or Omission	Occurrences	Paid Occurrences	Total Indemnity	Average Indemnity
Emotional distress - no physical injury	57	15	$939,000	$162,500
Sprain, damage to tendons	18	8	$567,950	$70,994
Cut, perforation, or tear to nerve	12	4	$1,555,000	$388,750
Amputation of hand or foot	11	4	$825,000	$206,250
Amputation of one limb	31	13	$6,868,519	$528,348
Amputation of two or more limbs	3	1	$608,384	$608,384
Cauda equine syndrome	7	4	$1,907,472	$476,868
Brachial plexus injury or disorder	14	9	$4,951,187	$550,132
Cerebral palsy	9	4	$3,650,000	$912,500
Paraplegia	24	12	$10,999,618	$916,635
Quadriplegia	19	12	$21,140,000	$1,761,667
Cut, perforation or tear to internal organ	46	9	$3,056,122	$339,569
Permanent partial loss of organ or organ function	55	12	$3,328,833	$277,403
Permanent full loss of organ or organ function	36	16	$9,482,206	$592,638
Death	784	315	$101,822,579	$323,246

Appendix 5: Malpractice Carriers in Missouri, 2007

Market Share by Company Licensure Status Missouri, 2007					
NAIC Group Code	NAIC Company Code	Company	Premium Written, 2007	Market Share of Given Licensure Type	Total Market Share
		Licensed Companies			
3504	10222	Paco Assurance Company, Inc.	$55,953	0.0%	0.0%
0244	10677	Cincinnati Insurance Company	$1,732,308	1.0%	0.8%
0861	10686	Medical Liability Alliance	$8,887,121	5.3%	4.1%
0508	10801	Fortress Insurance Company	$196,460	0.1%	0.1%
2638	11127	Professional Solutions Insurance Company	$1,073,920	0.6%	0.5%
	11582	Missouri Professionals Mutual	$41,213,754	24.6%	19.0%
	11704	Physicians Professional Indemnity Association	$9,415,129	5.6%	4.3%
0031	11843	The Medical Protective Company	$15,609,756	9.3%	7.2%
	11964	Missouri Doctors Mutual Insurance Co	$4,601,506	2.8%	2.1%
0140	11991	National Casualty Company	$8,771	0.0%	0.0%
	12361	Galen Insurance Company	$2,621,485	1.6%	1.2%
	12513	Professional Liability Insurance Company Of America	$4,350,105	2.6%	2.0%
	12754	Medicus Insurance Company	$46,654	0.0%	0.0%
0775	13714	Pharmacists Mutual Insurance Company	$411,713	0.2%	0.2%
3504	14460	Podiatry Insurance Company Of America, A Mutual Company	$1,605,328	1.0%	0.7%
2638	15865	NCMIC Insurance Company	$1,360,033	0.8%	0.6%
0212	16535	Zurich American Insurance Company	$241,968	0.1%	0.1%
0501	16624	Darwin National Assurance Company	$314,096	0.2%	0.1%
	18767	Church Mutual Insurance Company	$313,973	0.2%	0.1%
1313	18813	Dentists Benefits Insurance Company	$1,182	0.0%	0.0%
0012	19380	American Home Assurance Company	$88,654	0.1%	0.0%
0012	19445	National Union Fire Insurance Company Of Pittsburgh, Pa.	$2,638,748	1.6%	1.2%
0361	19720	American Alternative Insurance Corporation	$66,416	0.0%	0.0%
0218	20427	American Casualty Company Of Reading, Pennsylvania	$3,318,989	2.0%	1.5%
0761	21857	The American Insurance Company	$107,810	0.1%	0.0%
0761	21865	Associated Indemnity Corporation	$0	0.0%	0.0%
0761	21881	National Surety Corporation	$0	0.0%	0.0%
1129	21970	Onebeacon Insurance Company	$103,740	0.1%	0.0%
0626	22667	Ace American Insurance Company	$750,515	0.4%	0.3%
0761	22810	Chicago Insurance Company	$934,825	0.6%	0.4%
0012	23809	Granite State Insurance Company	$61,650	0.0%	0.0%
0163	24732	General Insurance Company Of America	$4,386	0.0%	0.0%
0176	25143	State Farm Fire And Casualty Company	$84,808	0.1%	0.0%
0861	27642	Missouri Hospital Plan	$29,166,787	17.4%	13.4%
2358	32921	Ismie Mutual Insurance Company	$314,613	0.2%	0.1%
1272	33367	Intermed Insurance Company	$6,890,822	4.1%	3.2%
2698	33391	The Medical Assurance Company, Inc.	$19,130,582	11.4%	8.8%
0831	34495	Doctors Company, An Interinsurance Exchange	$4,405,522	2.6%	2.0%
	34703	Kansas Medical Mutual Insurance Company	$2,435,339	1.5%	1.1%

Market Share by Company Licensure Status Missouri, 2007					
NAIC Group Code	**NAIC Company Code**	**Company**	**Premium Written, 2007**	**Market Share of Given Licensure Type**	**Total Market Share**
	35904	Health Care Indemnity Inc.	$355,268	0.2%	0.2%
	36234	Preferred Professional Insurance Company	$2,367,952	1.4%	1.1%
		Total Licensed	**$167,288,641**	**100.0%**	**76.9%**
		Risk Retention Groups			
	10232	American Association Of Orthodontists Insurance Co. (A RRG)	$118,507	0.7%	0.1%
	11710	Allied Professionals Insurance Company, A RRG	$28,481	0.2%	0.0%
	11712	Saint Lukes Health System Risk Retention Group	$3,538,422	21.4%	1.6%
	11714	Emergency Physicians Insurance Co Risk Retention Group	$562,249	3.4%	0.3%
	11798	Continuing Care Risk Retention Group, Inc.	$63,649	0.4%	0.0%
	11832	Health Care Industry Liability Reciprocal Insurance Co A RRG	$2,475,874	15.0%	1.1%
	11846	Peace Church Risk Retention Group (A Reciprocal)	$57,432	0.3%	0.0%
	11941	Green Hills Insurance Company, A Risk Retention Group	$3,751	0.0%	0.0%
	11947	Lewis & Clark LTC Risk Retention Group, Inc.	$99,047	0.6%	0.0%
	11990	Essential Risk Retention Group, Inc.	$1,775,721	10.7%	0.8%
	12015	Emergency Medicine Risk Retention Group, Inc	$293,618	1.8%	0.1%
	12907	Southwest Physicians Risk Retention Group, Inc.	$537,651	3.3%	0.2%
	12915	Urgent Care Assurance Company Risk Retention Group	$7,485	0.0%	0.0%
	13893	Community Blood Centers' Exchange, Risk Retention Group	$197,335	1.2%	0.1%
	36072	National Guardian Risk Retention Group	$1,807,469	10.9%	0.8%
	44083	Preferred Physicians Medical Risk Retention Group, Inc.	$2,975,404	18.0%	1.4%
	44105	Ophthalmic Mutual Insurance Company (A RRG)	$1,229,906	7.4%	0.6%
0508	44121	OMS National Insurance Company, Risk Retention Group	$749,610	4.5%	0.3%
		Total Risk Retention Group Business	**$16,521,611**	100.0%	**7.6%**
		Surplus Lines Companies			
2698	10179	Red Mountain Casualty Insurance Company, Inc.	$15,961	0.0%	0.0%
	10717	Aspen Specialty Insurance Company	$32,327	0.1%	0.0%
0361	10786	Princeton Excess And Surplus Lines Insurance Company	$2,149,567	6.4%	1.0%
1120	10851	Everest Indemnity Insurance Company	$607,061	1.8%	0.3%
	12189	Oceanus Insurance Company A Risk Retention Group	$649,192	1.9%	0.3%
3494	12203	James River Insurance Company	$24,079	0.1%	0.0%
	12373	Caring Communities, A Reciprocal Risk Retention Group	$1,457,724	4.3%	0.7%
0866	13196	Western World Insurance Company	$427,944	1.3%	0.2%
0012	19437	Lexington Insurance Company	$2,479,315	7.4%	1.1%
0031	20079	National Fire & Marine Insurance Company	$787,944	2.3%	0.4%
1279	21199	Arch Specialty Insurance Company	$4,902,491	14.6%	2.3%
0761	22829	Interstate Fire & Casualty Company	$202,833	0.6%	0.1%
0501	24319	Darwin Select Insurance Company	$594,308	1.8%	0.3%
0098	24856	Admiral Insurance Company	$1,164,002	3.5%	0.5%
0212	26387	Steadfast Insurance Company	$1,535,201	4.6%	0.7%
0012	26883	American International Specialty Lines Insurance Company	$164,000	0.5%	0.1%
0626	27960	Illinois Union Insurance Company	$1,292,437	3.8%	0.6%
0218	31127	Columbia Casualty Company	$4,060,757	12.1%	1.9%
0501	33138	Landmark American Insurance Company	$1,107,947	3.3%	0.5%
1129	34452	Homeland Insurance Company Of New York	$739,615	2.2%	0.3%

Market Share by Company Licensure Status Missouri, 2007					
NAIC Group Code	**NAIC Company Code**	**Company**	**Premium Written, 2007**	**Market Share of Given Licensure Type**	**Total Market Share**
0831	34487	Professional Underwriters Liability Insurance Company	$95,138	0.3%	0.0%
0785	35378	Evanston Insurance Company	$3,890,258	11.6%	1.8%
0012	35637	Landmark Insurance Company	$316,722	0.9%	0.1%
0158	37079	Hudson Specialty Insurance Company	$4,813,689	14.3%	2.2%
0031	37362	General Star Indemnity Company	$112,044	0.3%	0.1%
0140	41297	Scottsdale Insurance Company	$13,397	0.0%	0.0%
0984	42374	Houston Casualty Company	$17,081	0.1%	0.0%
		Total Surplus Lines	**$33,653,034**	**100.0%**	**15.5%**
		Total	**$217,463,286**		**100.0%**